PRIOR AUTHORIZATION REQUEST

DIABETIC TESTING SUPPLIES (GLUCOMETERS AND TEST STRIPS)

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested supply? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving samples for the requested supply? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested supply with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has experienced a clinically significant response as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the requested diabetic testing supply? [] Glucometer (If checked, go to 8) [] Test strips (If checked, go to 13)		
8	Is the request for a formulary glucometer? [If yes, skip to question 10.]	Yes	No
9	Does the patient have a physical limitation (such as manual dexterity or visual impairment) that limits utilization of formulary glucometer? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 12.] [If no, no further questions.]	Yes	No
10	Is the current glucometer unsafe, inaccurate, or no longer appropriate based on patient's medical condition? [If yes, no further questions.]	Yes	No
11	Is the current glucometer no longer functioning properly, has been damaged, or was lost or stolen? [If yes, no further questions.]	Yes	No
12	Has the patient received more than 1 glucometer in the last 12 months? If yes, please document the quantity requested: _____ [No further questions.]	Yes	No
13	Is the request for formulary test strips? [If yes, skip to question 16.]	Yes	No
14	Does the patient have a physical limitation (such as manual dexterity or visual	Yes	No

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	impairment) that limits utilization of formulary test strips? [If yes, skip to question 16.]		
15	Does the patient have an insulin pump that requires a specific test strip? [If no, no further questions.]	Yes	No
16	Is the quantity requested GREATER THAN 150 test strips per 30 days? If yes, please document the quantity requested: _____ [If no, no further questions.]	Yes	No
17	Is the patient greater than 12 years of age? [If no, no further questions.]	Yes	No
18	Has the patient been newly diagnosed with diabetes or with gestational diabetes? [If yes, no further questions.]	Yes	No
19	Is the patient on an insulin pump? [If yes, no further questions.]	Yes	No
20	Is the patient on high intensity insulin therapy with documentation of need to routinely test more than 4-5 times daily? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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